MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

06647

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
King's Grant Manor

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Laurence R. Blackhurst

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Wilhemina Blackhurst

Living 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 6, 1885

8. AGE: Years	Months	Days	If less than one day
61	1	25	..... hrs. ..... min.

9. Birthplace: Phila. Penna.
(Town, county, and state)

10. Usual occupation: Executive

11. Industry or business: DuPont Co. (Wilmington)

FATHER
12. Name: Charles John Blackhurst
13. Birthplace: England

MOTHER
14. Maiden name: Ida Stevenson
15. Birthplace: Phila. Penna.

16. Informant: L.R. Blackhurst, Jr.
Address: Chestertown, Md.

17. Cremation
(Burial, cremation, or removal. Which?)
Date thereof: Feb. 4, 1947
(month) (day) (year)

Cemetery or crematory: Silverbrook Crematory

Location: Wilmington, Delaware

18. Funeral director: J. Willis Wells

Address: Chestertown, Maryland

19. Feb. 3, 1947
(Date rec'd by registrar)

Clara L. Barnes.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 31, 1947 19..... at 7:20P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 21, 1946 to Jan. 31 1947 and that I last saw him alive on Jan. 31. 1947 19.....

Immediate cause of death	DURATION
Coronary Thombosis	Immediate
Due to: Aterio Sclerosis	Several Yrs
Due to: Pariarteritis Nodosa	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank Jones M.D.

Chestertown Md. M. D. or other

Address Date signed 2-5-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00648

93d

Reg. Dist. No. 2030

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred: Near Eastern Neck Island.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall R.D. # 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Near Eastern Neck Island

(If rural, give LOCATION)

2.(a) If veteran, name war: World War # 1

3. (a) FULL NAME: Raymond C. Carr

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Margaret C. Carr

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): July 28 1890

8. AGE: Years	Months	Days	If less than one day
56	5	14	....hrs. ....min.

9. Birthplace: Seaford Delaware (Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business

FATHER 12. Name: Edward W Carr

13. Birthplace: Smyrna Delaware

MOTHER 14. Maiden name: Mary L. Coleman

15. Birthplace: Kent Co. Maryland

16. Informant: Mrs. Margaret C. Carr

Address: Rock Hall, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/14/47 (month) (day) (year)

Cemetery or crematory: Wesley Chapel

Location: Rock Hall, Maryland

18. Funeral director: Mamie V. William

Address: Chestertown, Maryland.

19. 1/14 (Date rec'd by registrar) 19 47 E. Elwood Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12 19 47 at 8:33 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-15 19 47 to 1/12 19 47

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
~~Cardiac failure~~	
Congestive heart failure	3 months
Due to: Myocarditis	4-5 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: R. Ruth W. Farr M. D. or other

Address: Chestertown, Md. Date signed 1-13-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 b

★ 00649

Reg. Dist. No. 203

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Bernard Davis

3.(b) Social Security Number: 215-20-0064

4. Sex	5. Color or race	6.(a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6.(b) Name of husband or wife: Ruth Cypress Davis

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): 9-9-1890

8. AGE:

Years	Months	Days	If less than one day
56	3	29	...hrs. ...min.

9. Birthplace: Rock Hall, Kent Co. Md.

(Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business

FATHER

12. Name: George Davis

13. Birthplace: Kent County, Md.

MOTHER

14. Maiden name: Rosa Harrison

15. Birthplace: Kent County Md.

16. Informant: Thelma Davis Bunker - Daughter

Address: Rock Hall, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-10-1947 (month) (day) (year)

Cemetery or crematory: Wesley Chapel

Location: Rock Hall — Rural

18. Funeral director: J. Willis Wells

Address: Chestertown Md

19. 1/8 1947 (Date rec'd by registrar) S Elwood Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7 1947, at 4.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-26 1946, to 1-7 1947

and that I last saw h. alive on 1-7 1947

Immediate cause of death	DURATION
Pulmonary hemorrhage	
Due to: Pulmonary Tuberculosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Albert A Burgard M. D. or other

Address: Rock Hall, Md Date signed: 1/7/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cooperation is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

60
15
400
473

60
360
15
435

~~Hudson Kelly~~

Grung Creek

Wadsworth 7½"

& Grass

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

00650

★ Reg. Diat. No. 2020

1. PLACE OF DEATH:

County: Kent

City or town: Almshouse, Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:
Almshouse

How long in hospital or institution? 14 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John W. Dent

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male 63	C	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1/7/85

8. AGE:

Years	Months	Days	If less than one day
63	0	6	____ hrs. ____ min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: Inmate of Almshouse

11. Industry or business

FATHER
12. Name: JOHN F DENT
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: FANNIE GRAY
15. Birthplace: MARYLAND

16. Informant: SADIE DENT JONES
Address: NEW YORK CITY

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 15/41 (month) (day) (year)

Cemetery or crematory: Ch. Cemetery QUAKER NECK

Location: NEAR Chestertown, Chestertown Md

18. Funeral director: Supt. Byron Sutton
Address: Chestertown · Md

19. Jan. 14 1941 (Date rec'd by registrar) Clara S. Barnes. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 13 1941, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1941, to Jan. 13 1941 and that I last saw him alive on Jan. 11 1941

Immediate cause of death	DURATION
Mitral Stenosis	6 months
Due to: Chr. Endocardial Infection	2 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Chestertown Md Date signed Jan 13/41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-55-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

00651

Reg. Dist. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred: 304 Cannon St. Kent & Queen Ann. Hospital

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 304 Cannon St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Simon Evans

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C	Widowed

6.(b) Name of husband or wife: (Est.) Alice Evans

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 15 1861

8. AGE: Years	Months	Days	If less than one day
85	9	26	..... hrs. ..... min.

9. Birthplace: Caroline Co. Va. (Town, county, and state)

10. Usual occupation: Butler

11. Industry or business: Voshell Hotel - Chestertown

FATHER 12. Name: Thornton Evans

13. Birthplace: Port Royal Va.

MOTHER 14. Maiden name: Agnes Clark

15. Birthplace: Port Royal Va.

18. Informant: Mrs. Chas. Ashman (Niece)

Address: Chestertown, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/13/47 (month) (day) (year)

Cemetery or crematory: Chestertown

Location: Chestertown, Maryland.

18. Funeral director: Marion C. Williams

Address: Chestertown, Maryland.

19. Jan. 13, 1947 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 1947, at 8.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-7 1947 to 1-10 1947

and that I last saw him alive on ..... 19.....

Immediate cause of death: Cancer; senility. — DURATION: 2 mos.

Due to: Arteriosclerosis. Cure.

Due to: —

Other conditions: This man had no relatives nor any close friends. (Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. Dutton Scott, M. D. or other

Address: Chestertown, Md. Date signed 1-13-47

1-35

Evidence for the change of usual residence of mother is shown on G 108 2/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 20 20

1. PLACE OF DEATH
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants, give residence of mother)
State: Maryland County: Queen Anne's
City or town: Chestertown R.D.#1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sylvia Jane Farrell
3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan. 17, 1947
8. AGE: Years: | Months: | Days: 8 | If less than one day: hr. min.
9. Birthplace: Queen Anne's Co. Md. (Town, county, and state)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: Jas. Wm. Farrell
13. Birthplace: Queen Anne's Co. Md.

MOTHER
14. Maiden name: Bertha Fletcher
15. Birthplace: Queen Anne's Co. Md.

16. Informant: Mrs. Wm. Farrell
Address: Chestertown R.D. Md.

17. Burial, cremation, or removal. Which?: Burial
Date thereof: Jan 31 - 47 (month) (day) (year)
Cemetery or crematory: Pondtown
Location: Pondtown
18. Funeral director: Effan L. Lane
Address: Church Hill Md.

19. Jan 31 1947 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 30 1947, at 10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 28 1947 to Jan 30 1947; and that I last saw deceased alive on Jan 30 1947

	DURATION
Immediate cause of death: Lobar Pneumonia, Left	2 days
Due to: Malnutrition	
Due to: Bronchial Pneumonia	8 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dallas Griffith M.D. or other
Address: Chestertown Md. Date signed: Jan 31/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00653

Reg. Dist. No. 2020

1. PLACE OF DEATH:
County: Kent
City or town: Worton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: near Worton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Waller Fowler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Mamie Spry Fowler
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Jan. 29, 1876

8. AGE: Years	Months	Days	If less than one day
70	II	9	...hrs. ...min.

9. Birthplace: Kent Co. Maryland (Town, county, and state)
10. Usual occupation: Pipe fitter
11. Industry or business:

FATHER
12. Name: John Fowler
13. Birthplace: Kent Co. Maryland

MOTHER
14. Maiden name: Emma D. DeFord
15. Birthplace: Kent Co. Maryland

16. Informant: Mrs. Mamie Spry Fowler (wife)
Address: Worton Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 10, 1947 (month) (day) (year)
Cemetery or crematory: Chester Cemetery
Location: Chestertown, Md.

18. Funeral director: J. Willis Wells
Address: Chestertown, Maryland

19. Jan. 9 1947 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8. 1947, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10 1946, to January 7 1947 and that I last saw him alive on January 7th 1947

Immediate cause of death	DURATION
Pulmonary T. B.	1945
Due to	
Due to	
Other conditions Chronic Myocarditis with Senile Bronchitis (Include pregnancy within 3 months of death)	5 mo.

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Frank A. Smith M. D., or other
Address: Chestertown, Md. Date signed: 1/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83d 00654

83a

Reg. Dist. No. 203

1. PLACE OF DEATH:
County Kent
City or town Rock Hall - Rural - PINEY NECK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Rock Hall (Rural) PINEY NECK
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Oliver Erskine Frazier Sr.

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mildred A. Frazier
living
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): March 12, 1882
8. AGE: Years 64 | Months 10 | Days 3 | If less than one day hrs. min.
9. Birthplace: Rock Hall (rural) Kent Co Md
(Town, county, and state)
10. Usual occupation: Waterman
11. Industry or business
FATHER 12. Name: William Frazier
13. Birthplace: Dorchester Co Md.
MOTHER 14. Maiden name: Charlotte Austin
15. Birthplace: Baltimore Md.
16. Informant: Mrs. Mildred Frazier (wife)
Address: Piney Neck - Rock Hall, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 17, 1947 (month) (day) (year)
Cemetery or crematory: Wesley Chapel Cem.
Location: Near - Rock Hall, Md.
18. Funeral director: J. Willis Wells
Address: Chestertown, Maryland
19. Jan 17. 1947 (Date rec'd by registrar) S. Elwood Bryan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15 1947 at 6 A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1946, to Jan 14 1947
and that I last saw him alive on January 14 1947
Immediate cause of death: Lobar Pneumonia — DURATION 10 days
Due to: 3 other attacks of Pneumonia
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank W. Smith M. D., or other
Address: Chestertown Md Date signed 1/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

00655

Reg. Dist. No. 2020

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since age 16

Hospital, institution, or street address where death occurred: 106 E Cannon St. — Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 106 E. Cannon St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Jonas Haughton

3. (b) Social Security Number

4. Sex: M | 5. Color or race: C | 6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: Mary A Haughton

6.(c) If alive, give age: Deceased years

7. Birth date of deceased (mo., day, yr.): Aug. 15, 1867

8. AGE: Years: 79 | Months: 5 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: Edenton, North Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Fertilizer Factory

FATHER — 12. Name: Solomon Haughton

FATHER — 13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace:

16. Informant: Arlington T. Haughton

Address: 106 E Cannon St. Chestertown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 30 1947 (month) (day) (year)

Cemetery or crematory: Chestertown Cemetery

Location: Chestertown Md.

18. Funeral director: M. V. Williams

Address: Chestertown Md.

19. Jan. 30 1947 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 27 1947 at 10.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1947, to Jan 27 1947 and that I last saw him alive on Jan 27 1947

Immediate cause of death	DURATION
Due to: Coma	1 day
Due to: Cerebro sclerosis	2
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas T. Simpers M. D. or other

Address: Jan 28 47 Date signed: 1-28-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

00656

CERTIFICATE OF DEATH

Reg. Diat. No. 2001

1. PLACE OF DEATH:

County: Kent

City or town: Millington (If outside city or town limits, write RURAL and give nearest town) Md.

How long in above place of death? 24 years

Hospital, institution, or street address where death occurred: Ar Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Kent

City or town: Millington (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sadie Louise Goodman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Colored	Married

6.(b) Name of husband or wife: Wm. Goodman

6.(c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.): Feb 26 1900

8. AGE: Years	Months	Days	If less than one day
46 ~~47~~	1	19	hrs. min.

9. Birthplace: Wm. Ellis, Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: -

FATHER — 12. Name: Edward Banks

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Annie Tilles

MOTHER — 15. Birthplace: Md

16. Informant: Wm. Goodman

Address: Millington Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 11 1947 (month) (day) (year)

Cemetery or crematory: Millington Colored

Location: Millington Md.

18. Funeral director: Edward Fellows

Address: Millington Md.

19. Jan. 11 1947 (Date rec'd by registrar) Edward Fellows Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 7 1947 at 6.45 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 43 19.. to Jan. 7 1947

and that I last saw h.. alive on Jan. 7 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	6 days
Due to: Hemiplegia	1943
Due to: Arteriosclerosis & Nephritis	1940
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Millington Md. Date signed: Jan. 8/47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2-25

2-2000 —— 2-10

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 181

00657

CERTIFICATE OF DEATH

Reg. Dist. No. 2020

1. PLACE OF DEATH: Kent
County
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Hours
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 11 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war World War I

3.(a) FULL NAME Herbert Mellor

3.(b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Eliz. Locke Mellor
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) July 20 1896
8. AGE: Years 50 Months 5 Days 20 If less than one day ... hrs. ... min.
9. Birthplace Philadelphia Pa
(Town, county, and state)
10. Usual occupation Boat officer
11. Industry or business Shipping
FATHER 12. Name John Mellor
13. Birthplace England
MOTHER 14. Maiden name not known
15. Birthplace not known
16. Informant Records Kent & Queen Anne
Address Chestertown Md. Hosp.
17. Burial Date thereof Jan 11 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Still Pond Md
Location Still Pond Md
18. Funeral director B R Fellows
Address Still Pond Md
19 Jan. 10 1947 Clara S. Barnes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1947, at 5:45 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Did not attend Investigated death
and that I last saw h... alive on ...
Signed certificate as deputy
Immediate cause of death Med Exam Kent Co.
3rd Degree Burns DURATION 10 hrs
Due to Shock Hemorrhages
Due to Neck Back
Other conditions Partial Paralysis 7 yrs
Artero Sclerosis
(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of Jan 8/47
Where did injury occur? Betterton Kent
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Burn Injured at work? 1/8/47

23. SIGNATURE Frank Hines M.D.
Deputy Med Examiner
M.D. or other
Address Chestertown Md Date signed Jan 9/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

CERTIFICATE OF DEATH

00658

Reg. Dist. No. 2021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 days
Hospital, institution, or street address where death occurred:
Kent and Queen Anne's
How long in hospital or institution? 40 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Still Pond
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Ella Sparks Pennington

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William D. Pennington
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 24, 1864

8. AGE: Years	Months	Days	If less than one day
82	3	5	..... hrs. ..... min.

9. Birthplace: Near Chestertown, Kent, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Solomon Sparks
FATHER 13. Birthplace

MOTHER 14. Maiden name: Frances Baker
MOTHER 15. Birthplace: Nr. Chestertown, Kent, Md.

16. Informant: Hospital Records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 31 '47 (month) (day) (year)
Cemetery or crematory: Still Pond
Location: Still Pond, Md.

16. Funeral director: B.R. Fellows per V.N.K.
Address: Still Pond, Md.

19 Jan. 30 1947 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29 19 47 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 30 1946 to January 29 1947 and that I last saw h[illegible] alive on January 29 1947

Immediate cause of death	DURATION
Myocardial failure	10 days
Due to Senility	
Due to Accidental fall. Cont. R.	
Other conditions Fracture Lgt hip.	40 days

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident. Date of December 19, 1946.
Where did injury occur? Still Pond, (City or town) Kent. (County) Maryland. (State)
Injured at home, farm, industry, public place (where?) At home.
Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: A.C. Dick, M.D. M. D. or other
Address: Chestertown, Md. Date signed 1-29-47

1-35

00659

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 2 021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred: Queen St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Queen St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Herbert C. Perkins

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Clara V. Perkins

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): September 10 1875

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
71	4	7		

8. Birthplace: Chestertown Maryland (Town, county, and state)

10. Usual occupation: attorney

11. Industry or business: Law

FATHER 12. Name: James Alfred Perkins

FATHER 13. Birthplace: Chestertown Kent Co. Md.

MOTHER 14. Maiden name: Mary Chi. Blackiston

MOTHER 15. Birthplace: Kent Co. Maryland

18. Informant: Mrs. Clara V. Perkins

Address: Chestertown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/20/47 (month) (day) (year)

Cemetery or crematory: Chester

Location: Chestertown, Maryland

18. Funeral director: Harris V. Williams

Address: Chestertown, Maryland

19 Jan. 20 1947 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17 19 47, at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-15 19 47, to 1-17 19 47

and that I last saw h[illegible] alive on 1-17-47 19

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to: Coronary arteriosclerosis	many years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. Neil W. Farr M. D. or other

Address: Chestertown, Md Date signed 1-18-47

1-35

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

00660

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:
County Kent
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 58
Hospital, institution, or street address where death occurred: Kent and Queen Annes
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Water
(If rural, give LOCATION)
2.(a) If veteran, name war World War I

3.(a) FULL NAME Donald Ferguson Stam

3.(b) Social Security Number no

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Leonore Wilmer Stam
living
6.(c) If alive, give age .... years
7. Birth date of deceased (mo., day, yr.) December 18, 1888

8. AGE:

Years	Months	Days	If less than one day
58	0	25	........hrs. ....min.

9. Birthplace Chestertown, Kent, Maryland
(Town, county, and state)
10. Usual occupation Pharmacist
11. Industry or business Drug

FATHER
12. Name Colin Stam
13. Birthplace Maryland

MOTHER
14. Maiden name Annie Roberts
15. Birthplace North Carolina

16. Informant Hospital Records
Address Chestertown, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Jan. 14, 1947
(month) (day) (year)
Cemetery or crematory Chester Cem.
Location Chestertown, Md.

18. Funeral director J. Willis Wells
Address Chestertown, Md.

19 Jan. 13, 1947 Clara S. Barnes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 1947, at 7:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6 1947, to January 12 1947
and that I last saw him alive on January 12 1947

Immediate cause of death	DURATION
Coronary occlusion	6 days
Apoplexy	6 days
Due to Coronary insufficiency	3 years
Due to Hypertension	3 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....
Date of op. ....
Autopsy results ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work? ....

23. SIGNATURE A. C. Dick, M.D.
M. D. or other
Address Chestertown, Md. Date signed 1-12-47

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

195d

00661

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Kent & Queen Anne Co. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Queen Anne
City or town: R.F.D. * Chestertown, Md. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: Walter Albert Taylor

3.(b) Social Security Number

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife: none
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Dec. 30. 1946
8. AGE: Years 0 Months 0 Days 15 If less than one day ... hrs. ... min.
9. Birthplace: Kent Co. Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: George Otto Taylor
13. Birthplace: Kent Co. Maryland

MOTHER
14. Maiden name: Florence K. Yackle
15. Birthplace: Phila. Penna

16. Informant: Mrs. George Otto Taylor
Address: Chestertown, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 15, 1947 (month) (day) (year)
Cemetery or crematory: Chesterx Cem.
Location: Chestertown, Md.
18. Funeral director: J. Willis Wells
Address: Chestertown, Md.

19. Jan. 15, 1947 (Date rec'd by registrar) Clara S Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 14 1947, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1947, to Jan 14 1947
and that I last saw h... alive on Jan 14 1947

Immediate cause of death: Anoxemia — DURATION: 2 Days
Due to: Inspiration of foreign material
Due to / Other conditions: into trachea (mucus)
(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Jan 12/47
Where did injury occur? Chestertown (City or town) Kent (County) Md (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury Injured at work?

23. SIGNATURE: [illegible] M.D. (M. D. or other)
Address: Chestertown Md Date signed: Jan 14/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83d 06662

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? born - Kent

Hospital, institution, or street address where death occurred: Francis

How long in hospital or institution? 2w

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown. Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Broad St.

(If roral, give LOCATION)

2.(a) If veteran, name war: No.

3. (a) FULL NAME: William C. Townsend

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: (Sd) Henrietta J. Porter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 1, 1868

8. AGE:

Years	Months	Days	If less than one day
78	2	23	..... hrs. ..... min.

9. Birthplace: Kent Co. Maryland (Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business: Power Boat: Captain

FATHER

12. Name: George C. Townsend

13. Birthplace: Kent Co. Maryland

MOTHER

14. Maiden name: Unknown.

15. Birthplace: ..

16. Informant: Mr. George C. Townsend (Son)

Address: Chestertown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/26/47 (month) (day) (year)

Cemetery or crematory: Chester

Location: Chestertown Kent Co. Maryland

18. Funeral director: Marin & Williams

Address: Chestertown, Maryland.

19. Jan. 26 1947 (Date rec'd by registrar) Clara S. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24 1947, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 17 1947, to Jan 23 1947, and that I last saw h[illegible] alive on Jan 23 1947.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 year
Due to: Left Hemiplegia	1942
Due to: Arteriosclerosis.	4 years
Other conditions: Prostatic Trouble	Jan 1 '47

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank W Leach M. D. or other

Address: Chestertown Date signed: Jan 24/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00663

1310

Reg. Dist. No. 203

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: Herbert Alphaus Urie

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	married

6.(b) Name of husband or wife: Mrs. Ethel Urie

6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.): July 6 1883

8. AGE: Years	Months	Days	If less than one day
63	6	—	....hrs. ....min.

9. Birthplace: Rock Hall, Md (Town, county, and state)

10. Usual occupation: Bank cashier

11. Industry or business: Peoples Bank of Chestertown

FATHER — 12. Name: Henry Urie

FATHER — 13. Birthplace: Rock Hall, Md

MOTHER — 14. Maiden name: Carrie Satterfield

MOTHER — 15. Birthplace: Rock Hall, Md

16. Informant: Mrs. Ethel Urie

Address: Rock Hall, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 8-1947 (mouth) (day) (year)

Cemetery or ~~crematory~~: Wesley Chapel

Location: Rock Hall Md.

18. Funeral director: Edgar L. Lane

Address: Church Hill Md

19. 1/7 1947 (Date rec'd by registrar) S. Elwood Bungam Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 1947, at 6.42 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 1946, to Jan 6 1947 and that I last saw h.. alive on Jan 5 1947

Immediate cause of death	DURATION
Uremia	
chron. nephritis	
Due to: Hypertension	
Due to: Arteriosclerosis	
chron. Endo-Myocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Albert A Burgard M. D. ~~or other~~

Address: Rock Hall, Md Date signed: 1/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

06664

CERTIFICATE OF DEATH

Reg. Diat. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:
208 Calvert St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME

Josephine Wells

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: John Wells

living 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1879

8. AGE: Years	Months	Days	If less than one day
67	4	3	hrs. min.

9. Birthplace: Kent Co. Maryland
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER 12. Name: Joseph Mitchell

13. Birthplace: Maryland

MOTHER 14. Maiden name: Charles-Anna Mitchell

15. Birthplace: Maryland

16. Informant: John Wells (husband)

Address: Calvert St. Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 16, 1947 (month) (day) (year)

Cemetery or crematory: Quaker Neck (col.) Cem.

Location: Near - Chestertown, Md.

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. Jan. 14 1947 (Date rec'd by registrar) Clara S. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 12 1947, at 1030 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 1 1947 to Jan 12 1947 and that I last saw h[illegible] alive on Jan 11 1947

	DURATION
Immediate cause of death: Coma	1 day
Due to: Apoplexy	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. C. Simpers M. D. or other

Address: Chestertown Date signed 1-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00665 2030

Reg. Diat. No. 92d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred: Shaptown

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No. Shaptown

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME Robert Wright

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Widowed

6.(b) Name of husband or wife: (Late) Jasmin Wright

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 26 189[illegible]

8. AGE: Years	Months	Days	If less than one day
72	10	27	..... hrs. ..... min.

9. Birthplace: Kent Co Maryland (Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business: oysterman

FATHER 12. Name: Joseph Wright

FATHER 13. Birthplace: Kent Co. Maryland

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: "

18. Informant: Mr. Clemente Wright

Address: Rock Hall, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/25/47 (month) (day) (year)

Cemetery or crematory: Sandy Bottom

Location: Near Faulk, Kent Co. Maryland

18. Funeral director: Marion V. Williams

Address: Chestertown Maryland

19. 1/25 1947 (Date rec'd by registrar) S Elwood Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22 1947 at 10:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1946, to Jan 22 1947

and that I last saw h[illegible] alive on Jan 22 1947

Immediate cause of death	DURATION
Chron Endo-Myocarditis	
Hypertension	
Due to: arteriosclerosis	
Due to: Gangrene of both feet	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Albert A Bergard M. D. or other

Address: Rock Hall Md Date signed 1/24/47

1-35